



MAINE BUREAU OF INSURANCE PREFERRED PROVIDER ARRANGEMENT ANNUAL REGISTRATION FORM

General Instructions: Title 24-A Chapter 32 §2678 requires the filing of annual information by preferred provider arrangements (PPAs) on or before **March 1 (license issued to the following year March 1)** in order to maintain PPA licensure. Either the information requested must be provided or an explanation of failure to provide the information must be provided. Please label all attachments with the section and item number to which they respond. Please submit the information requested on this registration form to: Consumer Health Care Division, Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333, Attention: Kim E. Davis.

NEW for 2019: Sections II, IV and V must be fully completed. In subsequent years, you may answer “no changes since 2019” AND attach a copy of last fully completed filing (for these sections only).

Information in Sections IV and V submitted by another carrier should not be re-submitted.

Applicants may be asked to provide such other information as the Superintendent of Insurance or his delegate may reasonably request.

Applicants are reminded that preferred provider arrangements must comply with Title 24-A MRSA Ch. 32 and 56-A, and with Bureau of Insurance Rule Ch. 360 and 850.

In addition to meeting the requirements of the preferred provider arrangement, each preferred provider administrator who directly or indirectly transfers funds, manages funds, adjusts claims or asserts control over the transfer of funds for the purpose of payment of provider services shall register with the superintendent as an insurance administrator pursuant to chapter 18. (Title 24-A Chapter 32 §2674-A)

Documents which applicants would like held as confidential must follow the “Instructions for Requesting Confidential Treatment of Documents Filed with the Bureau of Insurance”.

If you have questions, please contact Kim Davis at Kim.E.Davis@Maine.gov or (207)624-8550.

Registration Fee Pursuant to Title 24-A §601, the registration fee of \$100 is required to be sent to the Treasurer, State of Maine.

Section I. General Information

1. Name
2. Address
3. Contact person, telephone number, email address
4. NAIC company code (if applicable)
5. Federal I.D. number
6. Statutory home city/state

Section II. Third Party Administrators

NEW for 2019: Sections II, IV and V must be fully completed. In subsequent years, you may answer “no changes since 2019” AND attach a copy of last fully completed filing (for these sections only).

1. Attach a listing of names, addresses, phone numbers, and functions performed for any third party administrators used in Maine for claims processing, utilization review or other preferred provider arrangement (PPA) operations or functions.
2. Attach copies of all signed contracts or agreements with third party administrators which have been newly completed and/or modified.
3. Provide a complete listing of carriers that use the PPA network in Maine. The list should identify those plans that are self-funded and fully-funded.

Section III. Financial Statements

Attach complete audited financial statements for the most recently completed year. Such financial statements may be reviewed by an independent certified public accountant in lieu of an audit if the administrator does not handle money.

Section IV. Operations

NEW for 2019: Sections II, IV and V must be fully completed. In subsequent years, you may answer “no changes since 2019” AND attach a copy of last fully completed filing (for these sections only).

Summarize the general business operations:

1. Please provide: coverage provisions, benefits and any exclusions by category of service, type of provider and (if applicable) by specific service, including but not limited to the following types of exclusions and limitations:
 - A. Health care services limited in or excluded from coverage.
 - B. Health care services requiring copayments or deductibles paid by enrollees.
 - C. Restrictions on access to a particular provider type.
 - D. Health care services that are or may be provided only by referral.
2. Attach sample copies of contracts used with employers or other purchasers.
3. Attach copies of certificates, schedules of benefits, and other such materials provided to enrollees or to prospective enrollees. Attach a copy of the health plan member identification card, if issued. State whether the applicable forms have been approved by the Maine Bureau of Insurance.
4. Describe the compensation arrangement between the PPA and the provider. Demonstrate that provider contracts include provisions holding enrollees financially harmless for payment denials for improper utilization of covered health services in situations where the enrollee has used the services of a preferred provider in accordance with the terms of the plan.
 - A. If contracting with a physician-hospital organization (PHO), provide a copy of the signed contract.
 - B. Attach sample copies of provider contracts.
5. Describe the utilization review (UR) process, including:
 - A. Title 24-A, M.R.S.A. §4301-A(10-A) requires managed care plans to comply with a specific definition of “medically necessary health care”. Attach copies of documents demonstrating that the plan complies with this definition.
 - B. Describe the notification procedures for adverse determinations.
 - C. Describe the procedures for requests for reconsideration and appeals.

- D. Describe the circumstances under which an enrollee is entitled to independent external review and how this is communicated to enrollees.
- 6. Explain how the PPA limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other non-covered or out-of-plan services and limits on preexisting conditions and waiting periods.
 - 7. Describe the financial or other incentives for enrollees to use preferred providers.
 - A. Demonstrate that the benefit level differential between services rendered by preferred providers and non-preferred providers does not exceed 20% of the allowable charge for the service rendered unless the Superintendent waives this requirement for a given benefit plan pursuant to 24-A MSRA §2677-A(2).
 - B. Describe how the services of a nonpreferred provider will be covered without the application of any benefit level differential if a preferred provider is not reasonably accessible, unless the Superintendent waives the prohibition of this differential for a given benefit plan pursuant to 24-A MSRA §2673-A(3).
 - C. Describe how enrollees who live in areas with inadequate access to certain providers of covered benefits are made aware that they are able to obtain the covered benefit at no greater cost than if the benefit were obtained from participating providers.
 - 8. Describe the manner in which the PPA addresses the following:
 - A. The provision of appropriate and accessible care in a timely fashion.
 - B. Timely determinations of coverage issues.
 - C. An effective and timely grievance process.
 - D. The circumstances in which an enrollee may obtain a second opinion.
 - E. Procedures for maintaining and monitoring quality of care, including the process for removing a provider found to be providing poor quality care.
 - F. Procedures for ensuring confidentiality of medical records.

- G. Plan for providing services for rural and underserved populations and for developing relationships with essential community providers.
9. Provide procedures related to the development and use of a formulary, if the PPA provides coverage for prescription drugs but limits that coverage to drugs included in a formulary.
- A. Describe the formulary.
 - B. Provide procedures an enrollee must follow to obtain medicines that are subject to a formulary.
 - C. Describe the extent to which an enrollee will be reimbursed for the cost of a drug that is not on the formulary.
10. Describe the requirements for enrollees to obtain coverage of routine costs of clinical trials and how information is provided on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, §312.34, as amended.

Section V. Annual Experience Report

NEW for 2019: Sections II, IV and V must be fully completed. In subsequent years, you may answer “no changes since 2019” AND attach a copy of last fully completed filing (for these sections only).

Summarize the PPA’s annual experience, including but not limited to:

- 1. Provide the current and projected enrollment in Maine for the two calendar years following the date the PPA was originally filed or updated, as applicable. Current and projected enrollment shall be provided in a table showing the number of enrollees by county of residence.
- 2. Describe the provider network including:
 - A. A current list of all providers and facilities (both names and addresses of primary, specialty, hospitals and ancillary providers), a twelve-month average percentage of physicians in the network with open practices, and a description of the mechanism for identifying providers accepting new clients.
 - B. The ratio of primary care providers to enrollees by county.
 - C. A demonstration that physicians have admitting privileges at participating hospitals.
 - D. If health care services are provided by salaried health care professionals employed by the PPA, a list of the salaried professionals and the services provided.

- E. Written standards for access to basic health care services and a description of the basis for determining that the network is sufficient to meet those standards.
 - F. A map subdivided by town indicating the geographic distribution by service location of primary care and specialty providers and contracted facilities in the PPA's service area, each category of provider and facility to be separately identified.
 - G. Correlative data to support all requisite maps.
 - H. If any changes have been made since March 1, 2017, provide credentialing criteria and a recruitment plan for preferred providers. Demonstrate compliance with P.L. 2003, ch. 108 (which requires carriers to make credentialing decisions within 60 days after receiving a completed application from a provider).
 - I. Provide appointment scheduling guidelines and timeliness standards.
 - J. Provide policies and procedures for enrollees who wish to change primary care providers.
 - K. **NEW 2019** Please explain the plan for compliance with 24-A MRSA §4320K. Effective 1/1/19 carriers offering a health plan in Maine shall provide coverage for services performed by a licensed naturopathic doctor. A carrier shall demonstrate that the carrier's provider network includes reasonable access to all covered services, within the scope of practice of a naturopathic doctor.
3. Provide any other information that the organization may wish to submit which reasonably relates to its ability to operate, maintain or underwrite a preferred provider arrangement.